THE TEACHING HOSPITAL*

CHARLES ALLEN ASHLEY, M.D.

Director, Mary Imogene Bassett Hospital
Cooperstown, N. Y.

A MAJOR responsibility for graduate medical education can and should be assumed by the teaching hospitals. A spectrum of institutions and settings is included in the term "teaching hospitals." Included are the largest and most sophisticated of our academic medical centers and also smaller hospitals engaged in both primary medical care and referral practice. This group of hospitals includes institutions which have a variety of corporate structures and medical-staff organizations. The medical staffs of these hospitals are most qualified to determine the educational needs of young physicians who hope to function in similar settings.

Why is the question being asked, "Where should the responsibility for graduate education rest?" What is really being questioned is the suitability of the end product, the trained physician, to meet the expectations of a number of different groups with diverse interests within our society. Each group has its own expectations and views. The appropriate focal point for all of these diverse groups is the teaching hospital; probably it is only at the level of the hospital that these various forces can be evaluated and appropriate programs implemented.

Among these groups are the medical schools and the large academic medical centers. Through the Association of American Medical Colleges, medical schools have stated their desire to assume responsibility for the quality and content of graduate medical education. Most medical schools and large academic medical centers have a growing orientation toward subspecialization. The large and excellent academic medical centers apply the most sophisticated modern scientific methods to the care of the patient. That such a setting makes it difficult to train physicians for any other setting is of little concern; the centers deliver medical care in a fragmented manner appropriate to their size and spe-

*Presented in a panel, Where Should the Responsibility for Graduate Medical Education Rest? as part of a *Symposium on the Changing Scene in Graduate Medical Education* held by the Committee on Medical Education of the New York Academy of Medicine October 26, 1973.

cialization. For example, one major academic medical center last year recorded 60,000 surgical outpatient visits; yet only 16.5% of these were to general surgery; the remainder were to surgical subspecialty clinics. Similarly, 38,000 medical visits were recorded, of which only 19.1% were to general medicine. Again, the remainder were to various subspecialty clinics.

The end product, the young physician completing training in one of these institutions, is in fact what is desired. He has been molded in the image of those who trained him. He often wishes to practice in a similar environment, to deliver scientific medicine of the highest quality in a fragmented manner. Much of the shortage of physicians in smaller hospitals and rural areas, I believe, has resulted from this orientation of the large academic medical centers. The physician trained in such a hospital is either unable or unhappy practicing in another type of setting. If the responsibility for graduate education becomes influenced even more strongly by the medical schools, we shall see little change from the method now being used in these centers.

A second major group with its own expectations is the public. The public has assumed a certain responsibility for graduate medical education, even if somewhat indirectly, by pressures exerted on legislative bodies which control the funds for graduate medical education. People are concerned about the fragmentation of medical care. They do not know to whom to go. They believe that the present fragmented system is wasteful of time and money. They are unhappy about the present inaccessibility of medical care, whether it is due to maldistribution or to an over-all shortage of physicians. They are concerned that a mere increase in the number of physicians will simply perpetuate the prevailing unsatisfactory situation. They are concerned about the cost, not only of medical care but of postgraduate medical education. A subconscious question is asked by the relatives of many patients: "You may know how to do that but can we afford it?" It is argued that the sick are the least able to afford the educational expense, disregarding the fact that 85% of all hospital reimbursement now comes indirectly from the patient. The actual cost of in-hospital care of patients and the educational expense included in this cost are spread across the 85% of the population which is enrolled in some form of private or governmental insurance program. The remaining 15% who are not covered by insurance are in this position either through

some anomaly of coverage, which is correctible, or through choice. Those in the latter situation have benefited, while ill, from the services provided by physicians and, up to the point they became ill, had not borne any part of the cost of the education of those physicians. I do not believe that the direct assumption of postgraduate medical educational costs by the government would result in a more equitable distribution of these costs to the public than now occurs through the insurance mechanism.

The third group whose expectations have had a profound influence on graduate medical education is house officers. By means of the selection process house officers have influenced the form and content of their own educational programs. House officers today expect an educational experience, not just an opportunity to participate in the care of patients. They resent doing things that can be done by others who are less trained and experienced. They expect a level of compensation which will enable them to live decently while serving as house officers without adding to the debt they have already incurred in colleges and medical schools.

It is difficult to obtain the appropriate balance between caring for patients, or service functions, and education. The goal is the education of the student in the application of medical science and his humanity to the care of the patient. This cannot be accomplished without direct service. The student must also be taught both the limits of his knowledge and the methods of continuing his education for his lifetime. He must acquire the determination to question the results of his treatment and to maintain the appropriate dissatisfaction with his results that will stimulate him to seek new approaches to the relief of human suffering.

I have spoken of the expectations, the influence, and the resulting responsibility for graduate medical education exerted by the medical school, the public, and the student. What of the hospital? The conflict in goals and expectations between the hospital's governing bodies and those of the medical schools, in even the most prestigious of academic medical centers, is, at the least, troublesome and, on occasion, devastating. The primary orientation of the medical schools is to the education of the student, while that of the hospitals is to the care of the patient and to the education of the student to deliver that care in a hospital setting.

I have outlined those forces within the teaching hospital which, through expectations regarding the desired characteristics of the physician completing his graduate medical education, have influenced the content of training programs. These forces have assumed some responsibility for medical education. I believe that the final responsibility for such educational programs should remain with the teaching hospitals. For only there can all these forces be weighed and balanced. There is a valuable diversity in size and in the manner of delivery of health services among the teaching hospitals of the country. To force all of them to train physicians to treat patients in a manner perceived by the medical school and its large academic medical centers will satisfy only the expectations of medical schools. It will do little to train physicians to deliver health services in a wide variety of situations.

For example, the concept of the area health education center suggested by the Carnegie Commission's report on Higher Education and the Nation's Health* envisioned the development of 126 centers throughout the country. The primary responsibility of these centers would be postgraduate medical education and the education of technical and paramedical personnel. Such centers were envisioned as having firm affiliations with medical schools; for that reason the little federal financial support available for the development of such centers has gone to the medical schools.

I believe that the existing examples of such centers cited by the Carnegie Commission would never have developed had the financial support gone directly to the medical schools. The medical schools are likely to develop other centers in their own image. The schools are unlikely to develop training programs for physicians who will function well in settings with which the schools are unfamiliar. The principal force in motivating a student is the example set by his teacher. It seems to me almost impossible to train a physician to deliver medical services in way that differs from that of his instructor. For these reasons I believe that a major responsibility for graduate medical education should reside with the whole spectrum of hospitals that are included in the classification of teaching hospitals.

*The Carnegie Commission on Higher Education: *Higher Education and the Nation's Health.* New York, McGraw-Hill, 1970.